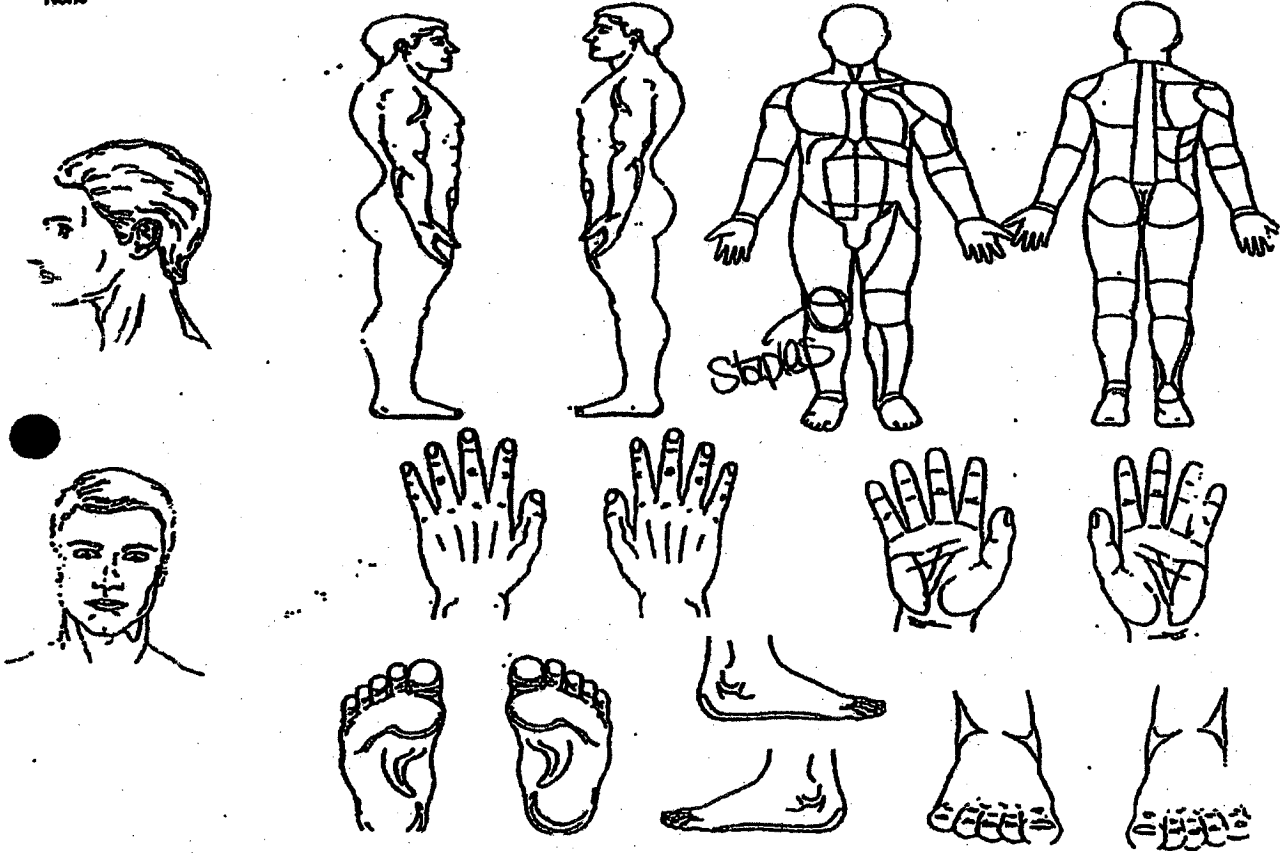
EXHIBIT -BBB

OTIS CLAY'S Medical Records
THAT ESTABLISH NO MULTIPLE FACIAL
FRACTURES OR MAJOR SKULL FRACTURE
WERE EVER INFLICTED UPON OR SUFFERED
BY MR. CLAY AS WAS FRAUDULENTLY
CLAIMED BY CHRIS CHILES, SEAN HAMMERS
AND RYAN BENTLEY —

ST. MARY'S MEDICAL CENTER

IF PATIENT HAS A SKIN IMPAIRMENT UPON ADMISSION, INDICATE ON FIGURE BELOW AND INITIATE SKIN CARE PROTOCOL ACCORDING TO THE STAGE OF THE WOUND AS ORDERED BY PHYSICIAN

LEGENDS:
Laceration - L
Decubitus - D
Hematoma - H
Scar - S
Bruise - B
Rash - R
None



Signature of Nurse Completing: _____ Date: 4/24/12 Time: 2300
Signature of Nurse Transferring: _____ Date: _____ Time: _____
Signature of Nurse Discharging: _____ Date: _____ Time: _____

SKIN ASSESSMENT-MALE
SMMC: 17-72M
Adopted Date: 12/03/2003
Revised Date: 5/07; 8/08
Reviewed:

Clay , Otis
110472370 / 04/09/2012
M / [redacted]
938 Washington Avenue / Denning, David
4184 / 467056

4/24/2012 7:45 PM

XVIII

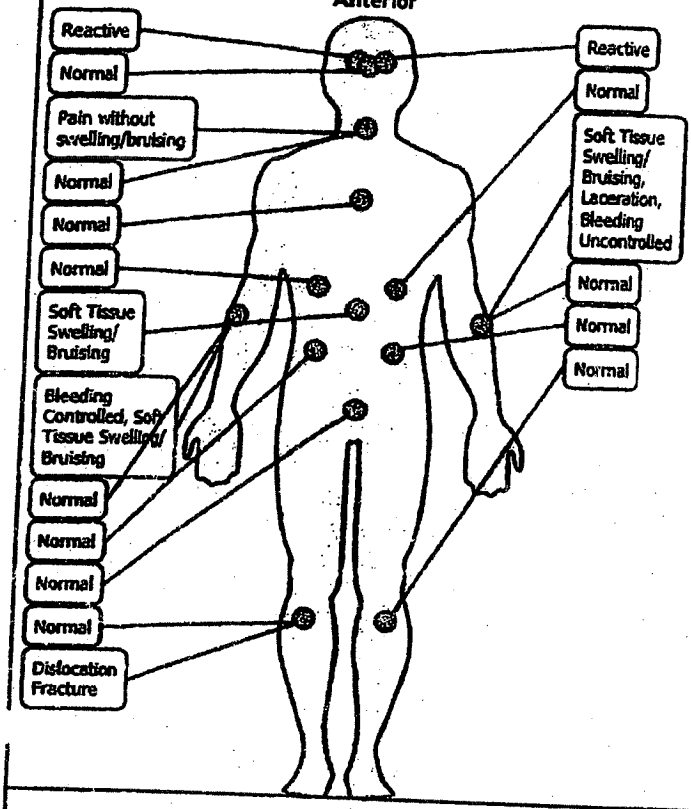
Date: April 9, 2012	Dispatch #: 12-07845	Response #: 2012-04-2-0068	Page: 2 of 5
Patient Name: OTIS CLAY		SSN: [redacted]	Issued On: 04/09/2012 05:12:43
PCR #: f03587c673b14dff82f318c2d7e5f9cc		Response Status: Complete	

Anatomical View

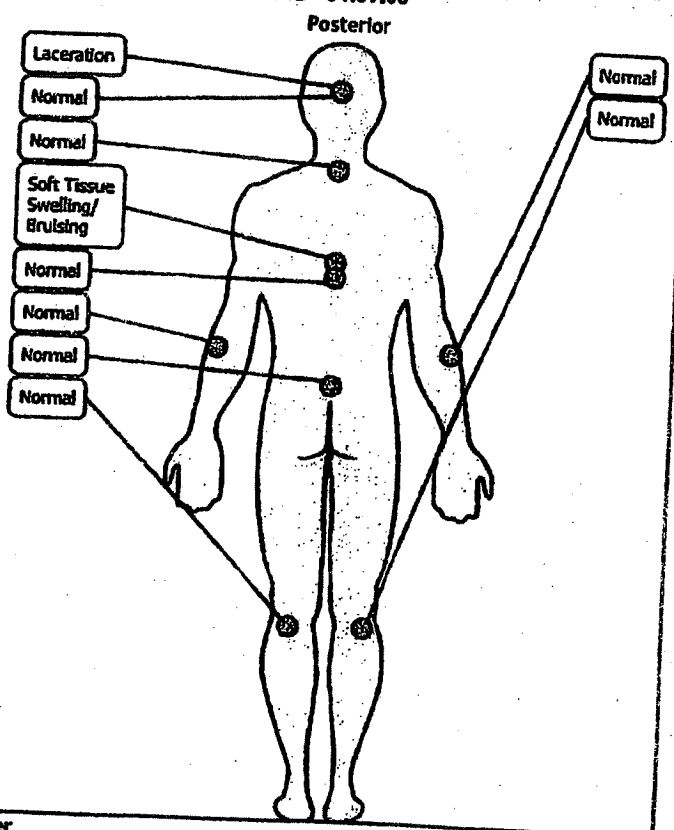
Crew Member: BURGESS, ADAM

Creation Date: 04/09/2012 - 01:39:00

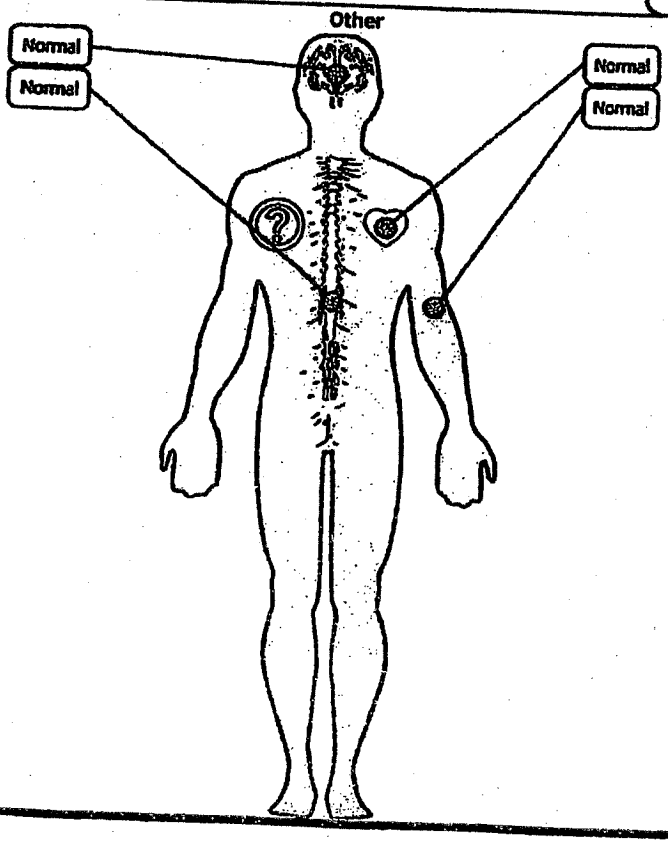
Anterior



Posterior



Other



XIV

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Date: April 9, 2012	Dispatch #: 12-07845	Response #: 2012-04-2-0068	Page: 3 of 5
Patient Name: OTIS CLAY		SSN: [redacted]	Issued On: 04/09/2012 05:12:43
PCR #: f03587c673b14dff82f318c2d7e5f9cc		Response Status: Complete	

Past Medical History

Current Medications

Comment:

Medication Description	Dose/Unit	Administration Route
List with patient		

Envir./Food Allergies:

Medications Allergies: Penicillin - PCN

Comment:

Past Medical History: COPD, Diabetes, Pacemaker / Defibrillator, Hypertension / HTN, TIA (Transient Ischemic Attack, Anxiety, Dementia

Medical / Surgical:

Obtained From: Patient

Comment:

Scene and Transport Delays

Type of Dispatch Delay: None

Type of Response Delay: None

Type of Scene Delay: Staff Delay

Type of Transport Delay: None

Type of Turn Around Delay: None

Event Chronology

Time: 01:29:00, Monday, April 09, 2012 - Event: PSAP (Public Safety Answering Point) Time

Time: 01:30:00, Monday, April 09, 2012 - Event: Call Time

Time: 01:31:00, Monday, April 09, 2012 - Event: Dispatched Time

Time: 01:33:00, Monday, April 09, 2012 - Event: Enroute Time

Time: 01:38:00, Monday, April 09, 2012 - Event: At Scene Time

Time: 01:39:00, Monday, April 09, 2012 - Event: At Patient Time

Time: 01:39:00, Monday, April 09, 2012 - Event: Procedure Performed

Attendant 1:	BURGESS, ADAM	Procedure:	ALS ASSESSMENT- ADULT
Number of Attempts:		Successful:	
Response:		Quantity:	
Size of Equipment:		Complications:	
Authorization:	Protocol (Standing Order)	Physician:	None
Obtained Prior to this Unit's EMS Care:	No	Performed By:	EMS Provider

Time: 01:39:00, Monday, April 09, 2012 - Event: Exam Assessment

Attendant: BURGESS, ADAM

Time: 01:39:00, Monday, April 09, 2012 - Event: Exam Assessment

Attendant:	BURGESS, ADAM	Neuro. Assessment:	
GU Assessment:	Normal	Eyes - Right:	Normal
Eyes - Left:	Reactive	Neck:	Reactive
Head/Face:	Normal	Head/Face:	Normal
Chest/Lungs:	Normal	Ext. Right Upper:	Normal
Ext. Right Upper:	Normal	Ext. Right Lower:	Normal
Ext. Right Lower:	Normal	Ext. Left Upper:	Normal
Ext. Left Upper:	Normal	Ext. Left Lower:	Normal
Ext. Left Lower:	Normal	Abdomen Right Upper:	Normal
Abdomen Right Lower:	Normal	Abdomen Left Upper:	Normal
Abdomen Left Lower:	Normal	Mental Status:	Normal
Heart:	Normal	Skin:	Normal
Back Lumbar/Sacral:	Normal	Back Cervical:	Normal
Back Thoracic:	Normal		Normal

Time: 01:40:00, Monday, April 09, 2012 - Event: Procedure Performed

Attendant 1:	BURGESS, ADAM	Procedure:	
Number of Attempts:		Successful:	SPLINT EXTREMITY
Response:		Quantity:	
Size of Equipment:		Complications:	
Authorization:	Protocol (Standing Order)	Physician:	None
Obtained Prior to this Unit's EMS Care:	No	Performed By:	EMS Provider

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Date: April 9, 2012	Dispatch #: 12-07845	Response #: 2012-04-2-0068	Page: 4 of 5
Patient Name: OTIS CLAY		SSN: [redacted]	Issued On: 04/09/2012 05:12:43
PCR #: f03587c673b14dff82f318c2d7e5f9cc		Response Status: Complete	

Time: 01:41:00, Monday, April 09, 2012 - Event: Medication Administered

Medication Given:	Oxygen	Date/Time Med. Given:	4/9/2012 01:41
Crew Member:	BURGESS, ADAM	Administered Route:	Non Rebreather
Dosage:	LPM 15	Response:	Unchanged
Complication:	None	Authorization:	
Med. Admin. Prior To This Unit's EMS Care:		Performed By:	EMS Provider
Authorizing Physician:			

Time: 01:42:00, Monday, April 09, 2012 - Event: Procedure Performed

Attendant 1:	BURGESS, ADAM	Procedure:	SPINAL IMMOBILIZATION
Number of Attempts:		Successful:	
Response:		Quantity:	
Size of Equipment:		Complications:	
Authorization:	Protocol (Standing Order)	Physician:	None
Obtained Prior to this Unit's EMS Care:	No	Performed By:	EMS Provider

Time: 01:43:00, Monday, April 09, 2012 - Event: Vital Sign Assessment

Attendant:	BURGESS, ADAM	Obtained Prior to this Unit's EMS Care:	No
BP Method:	Manual Cuff	SBP/DBP:	130/90
SaO2:	100	CO2 Level:	
AVPU:	Alert	Oriented:	Person, Place, Date/Time, Event
Pain Scale:	7	Pulse:	94
Pulse Quality:	Regular	Pulse Location:	Radial
Electronic Monitor Rate:		Resp.:	24
Resp. Quality:	Normal	Glucose:	
Temp:	°F	EKG Rhythm:	Normal Sinus Rhythm

GCS - Eye:
GCS - Verbal:
GCS - Motor:
GCS - Total:
GCS - Qualifier: Initial GCS has legitimate values without interventions such as intubation and sedation

For All Age Groups: 4 = Opens Eyes spontaneously
Patients >5 years: 5 = Oriented and appropriate speech
Patients >5 years: 6 = Obeys commands with appropriate motor responses

15

RTS:

12

Time: 01:49:00, Monday, April 09, 2012 - Event: IV Performed

Attendant 1:	BURGESS, ADAM	Procedure:	IV Start
Number of Attempts:	1	Successful:	No
Response:		Quantity:	
Size of Equipment:		Complications:	
Authorization:	Protocol (Standing Order)	Physician:	None
Obtained Prior to this Unit's EMS Care:	No	Performed By:	EMS Provider
Rate:		IV Site:	
Solution:		Total CCs:	
IV Gauge:	0		

Time: 02:05:00, Monday, April 09, 2012 - Event: Leave Scene Time

Time: 02:13:00, Monday, April 09, 2012 - Event: Vital Sign Assessment

Attendant:	BURGESS, ADAM	Obtained Prior to this Unit's EMS Care:	No
BP Method:	Automated Cuff	SBP/DBP:	103/81
SaO2:	100	CO2 Level:	
AVPU:	Alert	Oriented:	Person, Place, Date/Time, Event
Pain Scale:	7	Pulse:	104
Pulse Quality:	Regular	Pulse Location:	Radial
Electronic Monitor Rate:		Resp.:	22
Resp. Quality:	Normal	Glucose:	
Temp:	°F	EKG Rhythm:	Sinus Tachycardia

GCS - Eye:
GCS - Verbal:
GCS - Motor:
GCS - Total:
GCS - Qualifier: Initial GCS has legitimate values without interventions such as intubation and sedation

For All Age Groups: 4 = Opens Eyes spontaneously
Patients >5 years: 5 = Oriented and appropriate speech
Patients >5 years: 6 = Obeys commands with appropriate motor responses

15

RTS:

12

XVI

40

- CLAY, OTIS JUNIOR-Enc #110472370-IPT-TRA-Denning, David-4/9/2012-5/1/2012 Radiology CT Scan HEAD SCAN W/O CONTRAST 4/9/2012 1 pgs

ST-MARY'S MEDICAL CENTER

2900 1st AVE., HUNTINGTON, WV 25702 (304)526-1140

NAME: CLAY, OTIS **ADM#** 110472370 **DOB:** [redacted]

SEX: M **AGE:** [redacted] **PT CLASS:** E **HOSP SVC:**EMS

LOCATION: ORTH-5104B1 **RAD#** 566489 **MR#** 467056

ORDERING PHYSICIAN: RONALD DEE BOWE MD **ORD#** 90002
ORDERING COMMENTS:

Final Report

Date of Exam: 04/09/2012
Examination(s):

CT 0805 - CT HEAD SCAN W/O CONTRAST
ACC# 5654906

HISTORY/INDICATION: Status post assault.

REPORT: CT of the head demonstrates mild cortical atrophy. No evidence of acute hemorrhage is identified. The ventricles are normal bilaterally with no hydrocephalus or obstruction. Hypodense lesions are present within the deep white matter bilaterally, consistent with chronic microvascular ischemic disease.

CONCLUSION:
1. Cortical atrophy. No evidence of acute hemorrhage is noted.
2. Atherosclerotic vascular disease with periventricular white matter ischemic changes.

Interpreting Physician: GRANT PETTY MD
Transcribed by / Date: SW1 on Apr 9 2012 2:26P
Approved Electronically by / Date: PETTY MD GRANT Apr 10 2012 2:40A
Distribution: RONALD DEE BOWE MD

St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

OPERATIVE REPORT

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	**SURGEON:**	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	**ASST. SURGEON:**	
ROOM #:	5104	**ASSISTANT:**	
DATE OF PROCEDURE:	04/09/2012	**DICTATING:**	Steven C. Lochow, MD

PRELIMINARY REPORT UNTIL SIGNED

ANESTHESIA
Monitored anesthesia care.

PREOPERATIVE DIAGNOSIS

1. Right distal third femur fracture.
2. Left open elbow fracture.
3. Left 3rd phalanx fracture.

POSTOPERATIVE DIAGNOSIS

1. Right distal third femur fracture.
2. Left open elbow fracture.
3. Left 3rd phalanx fracture.

PROCEDURE

1. Placement of skeletal traction pin, right tibia.
2. Irrigation and debridement to left elbow wound with wound closure, simple. It was a 1-cm wound.

COMPLICATIONS
None.

ESTIMATED BLOOD LOSS
Minimal.

OPERATIVE INDICATIONS
The patient is a [redacted]year-old gentleman that was reportedly the victim of a home invasion and sustained the above injuries last night. Dr. Vivekanand Neginhal was on call. He asked me to assume his care today. I had a lengthy discussion with the patient and his family preoperatively. The patient was

St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

CONSULTATION

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	**CONSULTANT :**	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	**DICTATING:**	Steven C. Lochow, MD
ROOM #:	5104	**REFERRING:**	
DATE OF CONSULT:	04/09/2012		

PRELIMINARY REPORT UNTIL SIGNED

CHIEF COMPLAINT
Right femur fracture.

HISTORY OF PRESENT ILLNESS
The patient is a [redacted]-year-old gentleman who reportedly was assaulted during a home invasion last night. He initially came in on call and Dr. Neginhal was on call. He has asked me to assume his care today. The patient is awake and is quite somnolent. He is obviously a very poor historian. Most of the history is obtained from the chart and from his family members who are present. The patient is not quite sure what happened to him. One moment he says he was assaulted and the next moment he said he is not quite sure. He does tell me he has a history of heart problems.

PAST MEDICAL HISTORY
Past medical history was obtained from the chart again and from family members and is positive for:

1. Chronic obstructive pulmonary disease.
2. Nonischemic cardiomyopathy with an ejection fraction of 20% to 25%.
3. Atrial fibrillation.
4. Diabetes mellitus, type 2.
5. Congestive heart failure.
6. Hypertension.
7. Benign prostatic hypertrophy.
8. Alcohol abuse.

PAST SURGICAL HISTORY
Pacemaker placement in 2007.

SOCIAL HISTORY
The patient has had a smoking history of over 50 years; reportedly he quit 2 years ago. He has a history of alcohol use, but reportedly quit that 2 years

St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

CONSULTATION

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	CONSULTANT:	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	DICTATING:	Steven C. Lochow, MD
ROOM #:	5104	REFERRING:	
DATE OF CONSULT:	04/09/2012		

PRELIMINARY REPORT UNTIL SIGNED

ago as well. He lives alone.

ALLERGIES
Penicillin.

MEDICATIONS
Please see medication reconciliation form. He is not on any blood thinners secondary to noncompliance with Coumadin.

PHYSICAL EXAMINATION
The patient is awake. He is quite somnolent. He will follow some simple commands. Right lower extremity is shortened and internally rotated. There are no open wounds noted about the knee, thigh, or hip area. He will fire EHL, FHL, gastroc soleus, tibialis anterior. Light touch is grossly intact in his foot. He has brisk capillary refill. Left lower extremity is atraumatic. Right upper extremity is atraumatic. Left upper extremity is in a splint and a dressing out to his hand. Median, radial, and ulnar nerves are grossly intact. Light touch is grossly intact in his hands. He has brisk capillary refill in his fingers.

DIAGNOSTIC DATA
X-rays - Multiple views of the right femur show a distal third long oblique fracture. X-rays of the left elbow do not show any obvious fracture. It does appear to be a questionable fracture of lateral condyle, a very small thin wafer of bone. It does have some calcification around the left epicondyle of his elbow. X-rays of the left hand show a very comminuted middle phalanx fracture of his third digit.

ATTENDING PHYSICIAN
This is a [redacted]-year-old with right femur fracture, questionable left elbow fracture, and a left third finger fracture. The patient underwent irrigation and debridement of the left finger with closure in the ER. Because of his significant medical history and the fact at this point we have no information on his pacemaker and his family reports he has quite a bit of difficulty with

IX III

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St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

CONSULTATION

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	CONSULTANT:	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	DICTATING:	Steven C. Lochow, MD
ROOM #:	5104	REFERRING:	
DATE OF CONSULT:	04/09/2012		

PRELIMINARY REPORT UNTIL SIGNED

shortness of breath, I would like a cardiology evaluation prior to surgery. The family is in complete agreement with this plan. The patient will be taken to the operating room today for placement of a traction pin under sedation with local irrigation and debridement of his left elbow. Dr. Bolano will be attending to his left finger fracture. The patient was given tetanus and antibiotics in the emergency room.

D: SCL 04/09/2012 13:39
T: cdb 04/10/2012 04:34
JOB #: 403379
CC:

Signed by LOCHOW, STEVEN C. MD on 17-Apr-2012 10:08:12 -04:00

IX IV

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- CLAY, OTIS JUNIOR-Enc #110472370-IPT-TRA-Denning, David-4/9/2012-5/1/2012 Operative Report Steven C. Lochow, MD 4/9/2012 1 pgs

St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

OPERATIVE REPORT

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	**SURGEON:**	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	**ASST. SURGEON:**	
ROOM #:	5104	**ASSISTANT:**	
DATE OF PROCEDURE:	04/09/2012	**DICTATING:**	Steven C. Lochow, MD

PRELIMINARY REPORT UNTIL SIGNED

ANESTHESIA
Monitored anesthesia care.

PREOPERATIVE DIAGNOSIS

1. Right distal third femur fracture.
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PROCEDURE

1. Placement of skeletal traction pin, right tibia.
2. Irrigation and debridement to left elbow wound with wound closure, simple. It was a 1-cm wound.

COMPLICATIONS
None.

ESTIMATED BLOOD LOSS
Minimal.

OPERATIVE INDICATIONS
The patient is a [redacted]year-old gentleman that was reportedly the victim of a home invasion and sustained the above injuries last night. Dr. Vivekanand Neginhal was on call. He asked me to assume his care today. I had a lengthy discussion with the patient and his family preoperatively. The patient was

St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

OPERATIVE REPORT

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	**SURGEON:**	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	**ASST. SURGEON:**	
ROOM #:	5104	**ASSISTANT:**	
DATE OF PROCEDURE:	04/09/2012	**DICTATING:**	Steven C. Lochow, MD

PRELIMINARY REPORT UNTIL SIGNED

quite sleepy and confused. However, his family says this is baseline as he has a mental disability and the one family member is actually the power-of-attorney normally. I also have found that patient has extensive cardiac history as well as diabetes and atrial fibrillation, as well as having a pacemaker. At the time no one in the family or the patient knew what type of pacemaker it was. All this being considered, I felt the best course of action was to place a traction pin and simple irrigation and debridement, and bring the patient back for definitive fixation after he has been more thoroughly evaluated by a cardiologist. The family was in complete agreement with this plan. The risks and benefits of the above procedure were discussed. Informed consent was obtained from the power of attorney.

OPERATIVE PROCEDURE IN DETAIL

The patient was brought to the operating room. After adequate sedation was obtained, the patient was placed in supine position on the radiolucent table. The right lower extremity was prepped and draped in the usual sterile fashion. A traction pin was placed from lateral to medial just posterior to the tibial tubercle. Then 20 mL of 0.25% Sensorcaine was used for local. Traction pin was placed without difficulty. Sterile occlusive dressings were applied.

Next, the left upper extremity was prepped and draped in the usual sterile fashion. There was a small lateral wound that had been irrigated and closed in the emergency room. There was about a 1-cm wound over the medial epicondyle. There was no bone exposed. It was healthy tissue. I irrigated this with approximately 250 mL of fluid. It was a clean wound. I then closed it loosely using 3-0 nylon. Sterile occlusive dressings were applied.

Of note, the patient also had a wound on the volar surface of his middle finger. This had underwent irrigation and closure in the emergency room as well. So sterile occlusive dressings were applied and the patient's left upper extremity was placed in a sling. The patient was then taken back to the recovery room in stable condition.

St. Marys Medical Center

2900 First Avenue Huntington, West Virginia 25702 304-526-1234

OPERATIVE REPORT

NAME:	CLAY, OTIS JUNIOR		
ACCOUNT #:	110472370		
DATE OF BIRTH:	[redacted]	**SURGEON:**	Steven C. Lochow, MD
DATE ADMITTED:	04/09/2012	**ASST. SURGEON:**	
ROOM #:	5104	**ASSISTANT:**	
DATE OF PROCEDURE:	04/09/2012	**DICTATING:**	Steven C. Lochow, MD

PRELIMINARY REPORT UNTIL SIGNED

POSTOPERATIVE PLAN

He will be continued on antibiotics for 24 hours. I will ask Marshall Cardiology who has seen the patient in the past and reportedly has placed the defibrillator in 2007 to see and evaluate the patient. Once he is stabilized and optimized, we will bring him to surgery definitive fixation of the right femur. Dr. Luis E. Bolano will be addressing the left hand. The left elbow was stable to exam, and he can range and use this ad lib immediately.

D: SCL 04/09/2012 13:31
T: sst 04/10/2012 14:45
JOB #: 403374
CC:

Signed by LOCHOW, STEVEN C. MD on 17-Apr-2012 10:05:10 -04:00

- CLAY, OTIS JUNIOR-Enc #110472370-IPT-TRA-Denning, David-4/9/2012-5/1/2012 Radiology Preliminary x-ray report 4/10/2012 2 pgs

04/09/2012 04:00 FAX

04/09/2012 04:48 FAX 3048261131 SMH RADIOLOGY • ER 001/003

002

ST. MARY'S MEDICAL CENTER

ORDER REQUEST

Order Time: Apr 9 2012 2:26AM

STAT

NAME: CLAY, OTIS JUNIOR
ADDRESS: 938 WASHINGTON AVENUE
HUNTINGTON, WV 25704
PHONE: 0 -
ADM NO: 110472370
MED REC: 467056
SOC SEC NUMBER: - -
LAST EXAM DATE: 04/09/2012

DOB: [redacted]
AGE: [redacted]
RAD: 566489
SEX: M
PT CLASS: E
HOSP SERV: EMS
ROOM/BED: ENS1 0002A0
DEPARTMENT: RAD
PRIORITY: STAT
PREGNANT: N
ENCOUNTER#: 10404 RAD ORD#: 90003
DATE REQUESTED: Apr 9 2012 2:26AM
DIAGNOSIS: ASSAULT
ORDERED BY: _BRAGG

ORD DR: BOWE MD, RONALD DEE
ATT DR: BOWE MD, RONALD DEE
ADM DR: BOWE MD, RONALD DEE

REASON: ASSAULT

COMMENTS:

PATIENT DOB: [redacted]

RAD 1110 FEMUR (UPPER LEG) 2 VIEWS RT CPT: 73550 ACC# 5554909
RAD 0245 KNEE PATELLA 1 OR 2 V LT CPT: 73560 ACC# 5554910

PRELIMINARY REPORT:

Femur - Oblique fx of distal femur

L knee - effusion

JP

RAD 1110 FEMUR (UPPER LEG) 2 VIEWS RT CPT: 73550 ACC# 5554909
RAD 0245 KNEE PATELLA 1 OR 2 V LT CPT: 73560 ACC# 5554910
CLAY, OTIS pt class: E, STAT
MRN# 467056 RAD# 566489 DOB 05/31/1945 ENS1 0002A0
Date Requested Apr 9 2012 2:26AM
ADM Number

XXII

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04/09/2012 04:08 FAX 3046261131 SMH RADIOLOGY 001

ST. MARY'S MEDICAL CENTER
ORDER REQUEST

Order Time: Apr 9 2012 2:26AM
STAT

NAME: CLAY, OTIS
ADDRESS: UNKNOWN

DOB: [redacted]
AGE: [redacted]
RAD: 566489

Head - cortical atrophy
Ø acute

C spine - Sig DDD
Ø acute fx

Chest - Small Ⓑ pleural effusions, R>L
Post Ⓛ 9th & 10th rib fxs
Ø pneumo

Abd/pelvis - Ø solid organ/hollow viscus injury
Ø free air/fluid.

T/L spine - Ø acute fx
DDD

[redacted]

001/001 ER

04/09/2012 03:22 FAX

XIX 43

Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Last BM Date	04/07/2012 00:00
Elimination	Complete Voluntary Control
GI Assessment	No Problems/Normal/Regular BMs
Abdomen	Soft
Bowel Sounds	Present

Adm - Genitourinary

Voiding	No Difficulty
Mode of Elimination	To BR w/ Assist
Bladder	Normal

Adm - DVT Screen

VTE Risk Assessment Total	7
Age 41-60 Years	No
History of Major Surgery Within Previous 30 Days	No
ICU Admission	No
r/o Infection (elevated WBC, fever, inflammation, purulent dmg)	No
Obesity (BMI greater than 30)	No
Inflammatory Bowel Disease	No
Varicose Veins or Chronic Leg Edema	No
Oral Contraceptives or Hormone Replacement Therapy	No
Pregnancy or Post-Partum Within Previous 30 Days	No
Age 61 to 75	Yes
Major Surgery (any surg procedure w/anesthesia or resp assist)	No
r/o Acute MI	No
Current Respiratory Failure	No
Bed Confinement or Immobilization Greater Than 72 Hours	No
Indwelling Central Venous Catheter	No
Chronic CHF	No
COPD	No
History of Cancer	No
Age Greater than 75 years	No
History of DVT or PE	No
Thrombophilic	No
Stroke	No
Sepsis	No
Head Injury	No
r/o Acute Embolic Stroke	No
Acute Multi Trauma (within previous 30 days)	Yes
Acute Spinal Cord Injury (paralysis)	No
Elective Arthroplasty	No

XVII

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ST. MARY'S MEDICAL CENTER

ORDER OF RECORDING: 1. CHIEF COMPLAINT 2. HISTORY OF PRESENT ILLNESS 3. HISTORY OF PAST ILLNESS: (A)CHILDHOOD (B) ADULT (C)OPERATIONS (D) INJURIES 4.FAMILY HISTORY 5.SOCIAL HISTORY 6.SYSTEMIC REVIEW: (A)GENERAL (B)SKIN (C)HEAD-EYES-EARS-NOSE-THROAT (D)NECK (E)RESPIRATORY (F)CARDIO-VASCULAR (G)GASTRO-INTESTINAL (H)GENITO-URINARY (I)GYNECOLOGICAL (J)LOCOMOTOR (K) NEURO-PSYCHIATRIC 7. PHYSICAL EXAMINATION: (A)GENERAL (B)HEAD-EYES-NOSE-MOUTH & PHARYNX (C)CHEST-BREAST-LUNGS-HEART (D)ABDOMEN (E)GENITALIA OR PELVIC (F)REFLEXES (G)EXTREMITIES (H)NEUROLOGICAL 8. CLINICAL IMPRESSION 9. SIGNATURE 10.PROGRESS NOTES AS INDICATED.

DATE	TIME	
4/10/12	844	Physical/Occupational Therapy - Consult noted. Awaiting pt to have sx before initiating evaluation. Will check back tomorrow. [illegible] [illegible], student PT
		[illegible] [illegible]
		C. [illegible], OTR/L #1035
4/10/12	1145	Surgery Progress Note
		Pt seen & examined.
		S: Pt doing okay. Complaining of right knee pain. In skeletal traction. For definitive femur repair tomorrow. Was NPO for surgery on left arm but it was cancelled.
		O: Vitals T 98.2 P 91 R 20 BP 110/72 O_2 sat 100% RA
		Alert & oriented x3. Right leg in skeletal traction. Splint to left arm and dressing to left middle finger. Lac to parietal area well approximated with staples intact. Heart RRR ø murmur. Lungs clear. Abdomen soft, nontender. BS+. Moves all extremities. Pulses present. Good capillary refill.
		A/P: 66 yo male s/p Assault with right femur fx, left elbow fx, left middle fx, multiple left rib fx, scalp laceration, abrasions
		- Regular diet
		- Pain control
		- DVT/GI prophylaxis
		- Pulmonary toilet
		- OR tomorrow
		Signed by DENNING, DAVID MD on 03-Jun-2012 11:19:33 -0400 [illegible] FNP

PROGRESS NOTE #2
SMMC: 17-28
Adopted Date:
Revised Date: 10/09
Reviewed Date 10/02

4/9/2012 7:40 AM

Clay, Otis
110472370 / 04/09/2012
[redacted]
938 Washington Avenue / Bowe, Ronald Dee
5162 / 467056

XVIII

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

IVs Drain and Tubes Shift

Location IV Site #1	R Antecubital
Appearance IV Site #1	No Redness, Tenderness, Swelling or Warmth Noted
Size/Type IV #1	20G
Date IV #1 Inserted	04/09/2012 00:00
Dressing IV #1	Intact
Tubing Type IV #1	Extension (7 inch)
Date and Time of Patient Assessment	04/09/2012 15:00

Fall Risk Shift

Postural Hypotension	No
Hypoglycemic	No
Syncope or Dizziness	No
Anticonvulsant	No
Fallen Last 3 months	No
Mild Narcotic Analgesic	Yes
Fall Related Fx	Yes
Mod Narcotic Analgesic	Yes
Decreased Hearing	Yes
NSAID	No
Decreased Vision	Yes
Anti Anxiety Medication	No
Aphasia	No
Antipsychotic Meds	No
Unsteady Gait	Yes
Cardiac Medication	No
Confusion or Delirium	No
Hypnotic	No
Agitation or Anxiety	No
Antihypertensive Meds	No
Bowel Incontinence	No
Sedative, Antihistamine, or Antidepressant	No
Bladder Incontinence	No
Diuretic	No
Arrhythmia	No
Prosthesis	No
CHF	No
Cast Splints Slings	Yes
Dementia	No
Arthritis	No
Parkinsonism	No
Stroke Risk	No
Seizures Risk	No
Total Fall Risk	28

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Adm - All Chapters

Assessment Status Complete **Collected D Time** 4/9/12 9:28

Adm - All Chapters

Admit From	Home
Accompanied By	Alone
Source of Info	Patient
Pt Stated Reason for Adm	pt was assaulted.
Top 2 Concerns	Pain Control, Medical Outcome
ID Confirmed by Patient Name & Birthdate	Yes
Pt Armband	Yes
Knows or Told Attending Doctor Name	Yes
Info Regarding Access to Patient Information Given	Letter Given to Patient
Caffeine Use?	No
Alcohol Use?	No
Tobacco Use?	No Never Smoked
Glasses	Yes
Description	prescription
Location	Family/Friend
Dentures	Yes
Description	upper and lower
Location	Family/Friend
If belongings locations is family/friend	his glasses and upper dentures at pts home.
Other Belongings To Home	No valuables or belongings with patient.
Date and Time of Patient Assessment	04/09/2012 07:33

Adm - Past Med/Surg Hx

Family History	Alcohol Abuse, Cancer, Diabetes, Heart Disease, Hypertension, Kidney Disease, Stroke
Other Family History	patient has past hx of alcohol abuse

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Adm - Neurological

Med Rec Form Completed?	Yes
LOC	Lethargic
Behavior	Cooperative
Alert Status	Oriented X3
Sensory: Communication & Vision	Independent
Right Pupil Size	3 MM Small
Right Pupil Reaction	Sluggish
Left Pupil Size	3 MM Small
Left Pupil Reaction	Sluggish
Current Visual Disturbances	None
Difficulty Speaking	No
Problem Understanding?	No
Difficulty Swallowing?	No
Recurrent Hospital Admisison for Aspiration Pneumonia	No
Total Speech Score	0
Gait	Unsteady
Hand Grips	Weak Both
Upper Limb Function	Dependent Upon Assist in Self-Care
RUE Characteristics	Strong
RLE Characteristics	Strong
LUE Characteristics	Weak
LLE Characteristics	Weak
Mobility Status	Ambulate w/ Assist
Eye Opening	Spontaneous
Motor Response	Obeys Commands
Verbal Response	Appropriate
Glasgow Coma Scale	15

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	ORTH	**Rm/Bed:**	5104B1
Dx:			
Alrg:	Penicillins		

Fall Risk Shift

Postural Hypotension	No
Hypoglycemic	No
Syncope or Dizziness	No
Anticonvulsant	No
Fallen Last 3 months	No
Mild Narcotic Analgesic	No
Fall Related Fx	No
Mod Narcotic Analgesic	Yes
Decreased Hearing	No
NSAID	No
Decreased Vision	No
Anti Anxiety Medication	No
Aphasia	No
Antipsychotic Meds	No
Unsteady Gait	Yes
Cardiac Medication	Yes
Confusion or Delirium	No
Hypnotic	No
Agitation or Anxiety	No
Antihypertensive Meds	Yes
Bowel Incontinence	No
Sedative, Antihistamine, or Antidepressant	No
Bladder Incontinence	No
Diuretic	Yes
Arrhythmia	No
Prosthesis	No
CHF	No

Cast Splints Slings	Yes
Dementia	No
Arthritis	No
Parkinsonism	No
Stroke Risk	No
Seizures Risk	No
Total Fall Risk	16

Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	ORTH	**Rm/Bed:**	5104B1
Dx:			
Alrg:	Penicillins		

RN Shift Asmt

Assessment Status Complete **Collected D Time** 4/11/12 0:38

RN Shift Asmt

Pt Armband	Yes
ID Confirmed by Patient Name & Birthdate	Yes
Top 2 Concerns	Unable to Respond
LOC	Full Consciousness
Alert Status	Oriented to Person, Confused
Behavior	Cooperative, Sleeping
Speech	Clear
Mobility Status	Bedrest, Pain, Traction
Heart Rate Description	Regular/Normal
Heart Rhythm	Normal/Regular
Edema	None
Pacemaker	Yes
R Radial Pulse	+2 Normal
R Post Tibial Pulse	+2 Normal
R Dosal Ped Pulse	+2 Normal
L Radial Pulse	+2 Normal
L Post Tibial Pulse	+2 Normal
L Dosal Ped Pulse	+2 Normal
Capillary Refill	< 3 seconds
SCD/TED Hose	AVI Pumps, Bilateral Legs
Anticoagulants	Yes
Therapy Dosage	Lovenox 40mg SQ Daily
Recent	Invasive Procedure, Hgb and Hct
Respirations	Regular, Unlabored
Right Lung	Clear
Left Lung	Clear
Abdomen	Soft, Round
Bowel Sounds	Present
GI Tube 2	Not Applicable
Voiding	No Difficulty
Urine Color	Clear Yellow
Bladder	Normal
Mode of Elimination	Urinal
Braden Scale Completed for Today?	No
Skin Status	Intact/Good Turgor, Warm/Dry
Incision Location	right leg
Incision Description	skeletal traction to right leg with 25lbs on pin
Adverse Drug Reaction	No
Intensity Pain Site 2	5 Severe Pain
Location Pain Site 2	Right Leg
Pain Goal	1-Mild Pain
Shift Assessment Comment	Pt resting quietly in bed, no voiced complaints at this time. PT npo for surgery this am. Long arm splint to left arm, and elevated on pillow. Bed in low position, side rails x3, call light inreach.
Date and Time of Patient Assessment	04/11/2012 00:10

Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

RN Shift Asmt

Assessment Status Complete **Collected D Time** 4/9/12 16:51

RN Shift Asmt

Pt Armband	Yes
ID Confirmed by Patient Name & Birthdate	Yes
Top 2 Concerns	Pain Control, Medical Outcome
LOC	Lethargic
Alert Status	Oriented X3
Behavior	Cooperative
Speech	Clear
Sensation	2 = Normal Sensation
Stimulus Assessment	Verbal
Response Assessment	Purposeful
Neurological Comments	Pt states no numbness or tingling
Eye Opening	Spontaneous
Verbal Response	Appropriate
Motor Response	Obeys Commands
Glasgow Coma Scale	15
Right Pupil Size	3 MM Small
Right Pupil Reaction	Sluggish
Left Pupil Size	3 MM Small
Left Pupil Reaction	Sluggish
Facial Abnormalities	None
Right Upper	4 - Full ROM Sl Resist
Right Lower	4 - Full ROM Sl Resist
Left Upper	3 - Full ROM No Resist
Left Lower	3 - Full ROM No Resist
Heart Rate Description	Regular/Normal
Heart Rhythm	Normal/Regular
Pacemaker	Yes

R Radial Pulse	+2 Normal
R Post Tibial Pulse	+2 Normal
R Dosal Ped Pulse	+2 Normal
L Radial Pulse	+2 Normal
L Post Tibial Pulse	+2 Normal
L Dosal Ped Pulse	+2 Normal
Capillary Refill	< 3 seconds
Edema	None
SCD/TED Hose	AVI Pumps
Anticoagulants	No
Respirations	Regular, Unlabored
Right Lung	Clear, Diminished
Left Lung	Clear, Diminished
Abdomen	No Difficulty, Soft
Bowel Sounds	Present
Voiding	No Difficulty
Mode of Elimination	Brief/Diaper/Pad, Urinal
Braden Scale Completed for Today?	Yes
Skin Status	Intact/Good Turgor, Warm/Dry
Shift Assessment Comment	Pt in bed in low position with siderails up X3 and call light within reach.
Date and Time of Patient Assessment	04/09/2012 15:00

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Assessment: Resp Care Oxygen and Txs 4/9/12 11:31

Electronically Signed By:	Mccullough Leah RRT
Clinical Note	
Status	Complete
Oxygen Hours to Bill	12
Respiratory Device	Nasal Cannula
LPM or % O2	2 lpm
Treatment Orders	HH Neb
Treatment Medicaitons	Duoneb
Treatment Dosage	3 ML
Treatment Orders 2	Incentive Spirometry
Respiratory Treatment Comment	Instructed patient on incentive spirometry at this time. Patient reached a volume of 1.2 x 10. good effort.
Cough	Strong, Spont, Non-Prod,
Sputum Hx/Type	None
Breath Sounds Before Treatments	Diminished
Breathsounds After Treatment	No Change
Pulse	97 *H*
Site	Radial
Response to Treatment	Tolerated Well, Heart Rate Constant
O2 Saturation (%)	98

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Assessment Report

Pt Name:	Clay, Otis	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Bowe, Ronald MD
Nurse Sta:	ENS1	**Rm/Bed:**	0002A0
Dx:			
Alrg:	Not Assessed		

Assessment: Resp Care Oxygen and Txs 4/9/12 2:15

Electronically Signed By:	Abbess Karen D RRT
Clinical Note	
Status	Complete
Oxygen Hours to Bill	2
Respiratory Device	Nasal Cannula
LPM or % O2	2lpm
Treatment Orders	Trauma
Respiratory Treatment Comment	Responded to trauma alert II. Pt is in no respiratory distress at this time. Pt sats on 2lpm O2 is 100%
O2 Saturation (%)	100

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Skin Integrity Shift

Date and Time of Patient Assessment	04/09/2012 15:00
Site 1 Location	Right Scapula
Site 2 Location	left knee
Site 3 Location	left hand
Site 4 Location	Left Hip
Site 5 Location	abdomine
Electronically Signed By:	Michael K Stuart RN

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Skin Integrity Shift

Assessment Status Complete

Collected D Time 4/9/12 13:12

Skin Integrity Shift

Date and Time of Patient Assessment	04/09/2012 13:12
Site 1 Location	Right Scapula
Type Skin Impairment Site 1	Abrasion
Site 2 Location	left knee
Type Skin Impairment Site 2	Abrasion
Site 3 Location	left hand
Type Skin Impairment Site 3	Abrasion
Site 4 Location	Left Hip
Type Skin Impairment Site 4	Abrasion
Site 5 Location	abdomine
Type Skin Impairment Site 5	Abrasion
Electronically Signed By:	Teresa G Stewart CNA

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Adm - Cardiovascular

Heart Rate Description	Regular/Normal
Heart Rhythm	Normal/Regular
Pacemaker	Yes
Capillary Refill	< 3 seconds
Edema	Pedal Edema
R Radial Pulse	+2 Normal
L Radial Pulse	+2 Normal
R Post Tibial Pulse	+2 Normal
L Post Tibial Pulse	+2 Normal
R Dosal Ped Pulse	+2 Normal
L Dosal Ped Pulse	+2 Normal
Calf Edema	Normal - No Redness, Edema, or Tenderness

Adm - Respiratory

Respirations	Regular, Unlabored
Right Lung	Clear, Diminished
Left Lung	Clear, Diminished

Adm - Vitals

Temperature	97.9 F
Site	Oral
#Pulse	91
Site	Radial
Respirations	18
O2 Saturation (%)	100
BP	123/73
Site	Right Leg
Position	Lying
Method	Automated
How Obtained	Stated
How Obtained	Stated
Body Mass Index	27.89
Height	5/11 ft,in
Weight	200/0 lbs,oz

Adm - Gastrointestinal

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Hip, Pelvis, or Leg Fracture Within Previous 30 Days	No
Hip or Knee Replacement Within Previous 30 Days	No
Height	5/11 ft,in
Weight	200/0 lbs,oz
VTE Risk Score Definition	Highest Risk (Incidence 40-80%)
Body Mass Index	27.89

Adm - Braden Scale/Skin Risk

Sensory/Perception	Slightly Limited
Moisture	Occasionally Moist
Nutrition	Adequate
Mobility	Slightly Limited
Activity	Walks Occasionally
Friction and Shear	Potential Problem
Braden Score Total	17

Adm - Skin Integrity

Diagram Complete	Yes
Mucous Membranes	Moist
Turgor	Good
Site 1 Location	Right Scapula
Type Skin Impairment Site 1	Wound
Site 2 Location	left knee
Site 3 Location	left hand
Type Skin Impairment Site 3	Wound

Adm - Fall Risk

Postural Hypotension	No	Fallen Last 3 months	Yes
Hypoglycemic	No	Mild Narcotic Analgesic	Yes
Syncope or Dizziness	No	Fall Related Fx	Yes
Anticonvulsant	No	Mod Narcotic Analgesic	Yes

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Decreased Hearing	No
NSAID	No
Decreased Vision	No
Anti Anxiety Medication	No
Aphasia	No
Antipsychotic Meds	No
Unsteady Gait	Yes
Cardiac Medication	No
Confusion or Delirium	No
Hypnotic	No
Agitation or Anxiety	No
Antihypertensive Meds	No
Bowel Incontinence	No
Sedative, Antihistamine, or Antidepressant	No
Bladder Incontinence	No
Diuretic	No
Arrhythmia	No
Prosthesis	No
CHF	No
Cast Splints Slings	Yes
Dementia	No
Arthritis	No
Parkinsonism	No
Stroke Risk	No
Seizures Risk	No
Total Fall Risk	40

Adm - Nutrition

Number of meals a day?	2
Last Meal Dt/Time	04/08/2012 12:00
Home Diet	Diabetic
Follows Diet?	Yes
Difficulty Swallowing?	No
No Nutrition Risk Factors Identified	Yes

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Assessment Report

Pt Name:	Clay, Otis J		
Pt ID:	2012004264	**MRN:**	467056
DOB:	[redacted]	**Acct No:**	110472370
Adm DTime:	04/09/2012	**Age/Sex:**	[redacted]
Nurse Sta:	NEUR	**Atn Dr:**	Denning, David MD
Dx:		**Rm/Bed:**	5162B1
Alrg:	Penicillins		

Adm - Patient History

Source of Info	Patient
Language Spoken	English
Lives with	Other
Contact Person	Anne
Phone #(s)	no phone number.
Patient Responsible for Care of Someone?	No
Responsible Caregiver	Self
Hx Abuse/Neglect?	No
Feel safe at home?	Yes
Past History or Current Problem with	Unable to Assess
Learning Preferences	All Instruction Type
Reading Preferences or Needs	English
Oriented To	Call light, Phone, Smoking Policy, Visiting, Emergency Light, Bathroom, Bed Rails, RN ID-Navy Blue Border, LPN ID-Yellow Border

Adm - Advance Directives

Contact Person	Anne
Phone #(s)	no phone number.
LOC	Lethargic
Alert Status	Oriented X3
Court Appointed Guardian	No
Living Will?	Unable to Answer
Medical Power of Attorney?	Unable to Answer
Advanced Directive Info Given?	No Not Needed

Adm - Discharge Planning

Do you need assistance in arranging for a	No
PCP?	
Anticipated Discharge Mode	Auto

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Contact Person	Anne
Phone #(s)	no phone number.
Admitted From	Home Independent
Ambulation Functional	No Difficulty
Current Assistance Required with ADLs	No
Anticpated Discharge To	Home (Independent)
Home DME or O2?	No
Type of DME and Company Name	none
Social Service Referral Needed?	Other SS Consult
External Services Currently Received	None
Functional Total	7
Sensory: Communication & Vision	Independent
Elimination	Complete Voluntary Control
Upper Limb Function	Dependent Upon Assist in Self-Care

Adm - Pain Assessment

Is Pt Having Pain?	No
Pain Intensity	3 Moderate Pain
Pain Location	Head, Abdomen, Left Arm, Left Hand, Right Leg
Onset	Sudden
Pattern	Continuous
Time	All Times
Quality	Aching, Sharp, Throbbing
What makes it worse?	movement
Effect on ADLs	Movement, Sleep/rest, Activities
Relieved By	Positioning, Relaxation
Pain Goal 1	0 No Pain
If Pt. Not Having Current Pain Have They Had Recent Pain?	Yes

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	NEUR	**Rm/Bed:**	5162B1
Dx:			
Alrg:	Penicillins		

Electronically Signed By: Michael K Stuart RN

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	ORTH	**Rm/Bed:**	5104B1
Dx:			
Alrg:	Penicillins		

RN Shift Asmt

Assessment Status Complete

Collected D Time 4/9/12 21:08

RN Shift Asmt

Pt Armband	Yes
ID Confirmed by Patient Name & Birthdate	Yes
Top 2 Concerns	Pain Control, Medical Outcome
Recieved Poor Prognosis or Life Altering	No
LOC	Full Consciousness
Alert Status	Oriented to Person, Oriented to Place
Behavior	Cooperative
Speech	Clear
Right Pupil Size	Round, 4 MM Medium Normal
Right Pupil Reaction	Normal-Brisk
Left Pupil Size	Round, 4 MM Medium Normal
Left Pupil Reaction	Normal- Brisk
Mobility Status	Pain, Other
Neuro Comments	30 pounds skeletal traction to rle. Patient on bedrest.
Heart Rate Description	Regular/Normal
Heart Rhythm	Normal/Regular
Edema	None
Pacemaker	Yes
R Radial Pulse	+2 Normal
R Post Tibial Pulse	+2 Normal
R Dosal Ped Pulse	+2 Normal
L Radial Pulse	Not Accessible
L Post Tibial Pulse	+2 Normal
L Dosal Ped Pulse	+2 Normal
Capillary Refill	< 3 seconds
SCD/TED Hose	AVI Pumps
Addl Comment	good csm to toes of rle and good csm to fingers left hand. Left fa splint and index finger left hand splinted
Anticoagulants	No
Respirations	Regular, Unlabored
Right Lung	Clear
Left Lung	Clear
Abdomen	No Difficulty
Voiding	No Difficulty
Mode of Elimination	Brief/Diaper/Pad, Urinal
Braden Scale Completed for Today?	Yes
Adverse Drug Reaction	No
Intensity Pain Site 2	4 Moderate Pain
Location Pain Site 2	Left Arm, Right Leg
Pain Goal	2-Mild Pain
Shift Assessment Comment	Patient admited to floor in transfer from Neuro. Alert and oriented to person and place. area of eschar to back of head. No active drainage noted. sutures intact
Date and Time of Patient Assessment	04/09/2012 21:00

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Assessment Report

Pt Name:	Clay, Otis J		
Pt ID:	2012004264	**MRN:**	467056
DOB:	[redacted]	**Acct No:**	110472370
Adm DTime:	04/09/2012	**Age/Sex:**	[redacted]
Nurse Sta:	ORTH	**Atn Dr:**	Denning, David MD
Dx:		**Rm/Bed:**	5104B1
Alrg:	Penicillins		

Fall Risk Shift

Postural Hypotension	No
Hypoglycemic	No
Syncope or Dizziness	No
Anticonvulsant	No
Fallen Last 3 months	No
Mild Narcotic Analgesic	No
Fall Related Fx	No
Mod Narcotic Analgesic	Yes
Decreased Hearing	No
NSAID	No
Decreased Vision	No
Anti Anxiety Medication	No
Aphasia	No
Antipsychotic Meds	No
Unsteady Gait	Yes
Cardiac Medication	Yes
Confusion or Delirium	Yes
Hypnotic	No
Agitation or Anxiety	Yes
Antihypertensive Meds	Yes
Bowel Incontinence	No
Sedative, Antihistamine, or Antidepressant	No
Bladder Incontinence	Yes
Diuretic	No
Arrhythmia	No
Prosthesis	No
CHF	No
Cast Splints Slings	Yes
Dementia	No
Arthritis	No
Parkinsonism	No
Stroke Risk	No
Seizures Risk	No
Total Fall Risk	28

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	ORTH	**Rm/Bed:**	5104B1
Dx:			
Alrg:	Penicillins		

Skin Integrity Shift

Date and Time of Patient Assessment	04/09/2012 21:00
Site 1 Location	Right Scapula
Site 1 Other	ota. Area of eschar to back of head, no active drainage
Site 2 Location	left knee
Site 3 Location	left hand
Site 3 Other	splint with ace wrap. index finger to left hand with splint and kerlix dressing
Site 4 Location	Left Hip
Type Skin Impairment Site 4	Abrasion
Site 5 Location	abdomine
Type Skin Impairment Site 5	Abrasion

IVs Drain and Tubes Shift

Location IV Site #1	R Antecubital
Appearance IV Site #1	No Redness, Tenderness, Swelling or Warmth Noted
Size/Type IV #1	20G
Date IV #1 Inserted	04/09/2012 00:00
Dressing IV #1	Intact
Tubing Type IV #1	Extension (7 inch)
IV #1 on Pump?	Yes
Flushed All Unused Ports/Lines	Yes
All IV Connections Secure	Yes
Date and Time of Patient Assessment	04/09/2012 21:00
Electronically Signed By:	Dottie C Gibbs RN

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Assessment Report

Pt Name:	Clay, Otis J		
Pt ID:	2012004264	**MRN:**	467056
DOB:	[redacted]	**Acct No:**	110472370
Adm DTime:	04/09/2012	**Age/Sex:**	[redacted]
Nurse Sta:	ORTH	**Atn Dr:**	Denning, David MD
Dx:		**Rm/Bed:**	5104B1
Alrg:	Penicillins		

RN Shift Asmt

Assessment Status Complete

Collected D Time 4/10/12 17:21

Pt Armband	Yes
ID Confirmed by Patient Name & Birthdate	Yes
Top 2 Concerns	Pain Control, Medical Outcome
Recieved Poor Prognosis or Life Altering	No
LOC	Full Consciousness
Alert Status	Confused
Behavior	Cooperative
Speech	Clear
Mobility Status	Bedrest
Heart Rate Description	Regular/Normal
Heart Rhythm	Normal/Regular
Pacemaker	Yes
SCD/TED Hose	AVI Pumps, Bilateral Legs
Anticoagulants	Yes
Therapy Dosage	Lovenox 40mg SQ Daily
Respirations	Regular, Unlabored
Right Lung	Clear
Left Lung	Clear
Abdomen	No Difficulty, Soft
Bowel Sounds	Present
GI Tube 2	Not Applicable
Voiding	No Difficulty
Urine Color	Clear Yellow
Bladder	Normal
Mode of Elimination	Urinal
Braden Scale Completed for Today?	No
Skin Status	Intact/Good Turgor, Warm/Dry

RN Shift Asmt

Adverse Drug Reaction	No
Shift Assessment Comment	25# skeletal traction noted on the pin in right leg, pt is confused, urinal at bedside, good color, movement and sensation noted in the right leg, and left hand, call light within reach,bed in low position, all wts free hanging
Date and Time of Patient Assessment	04/10/2012 16:00

Type:

Assessment Report EDR
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Printed On: 10-Apr-12 17:36

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Assessment Report

Pt Name:	Clay, Otis J	**MRN:**	467056
Pt ID:	2012004264	**Acct No:**	110472370
DOB:	[redacted]	**Age/Sex:**	[redacted]
Adm DTime:	04/09/2012	**Atn Dr:**	Denning, David MD
Nurse Sta:	ORTH	**Rm/Bed:**	5104B1
Dx:			
Alrg:	Penicillins		

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Bladder Incontinence	No
Diuretic	Yes
Arrhythmia	No
Prosthesis	No
CHF	Yes
Cast Splints Slings	Yes
Dementia	No
Arthritis	No
Parkinsonism	No
Stroke Risk	No
Seizures Risk	No
Total Fall Risk	43

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